

**STRATEGIC CHANGE MANAGEMENT PRACTICES IN  
KENYATTA NATIONAL HOSPITAL**

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**By:**

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## DECLARATION

This Management Project is my original work and has not been presented for a degree in any other university.

Signed Kengaro

Date 18/01/05

**Kennedy Ongaro**

The Management Project has been submitted for examination with my approval as university supervisor.

Signed Maalu

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## DEDICATION

This project is dedicated to my wife Margaret Kerubo and to my children Charlene Bwari and Graham Otieri for their encouragement, patience, understanding and support and to my parents Jeremiah Ongaro and Ebisibah Nyaera who taught me to value and honour truth.

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## ABBREVIATIONS

WHO -	World Health Organization
KNH -	Kenyatta National Hospital
GOK -	Government of Kenya
MOH -	Ministry of Health
NCPB -	National Cereals and Produce Board
USAID -	United States Agency for International Development
UON -	University of Nairobi
CSSD -	Central Sterile Service Unit
TSSU -	Theatre Sterile Service Unit
AIDS -	Acquired Immune Deficiency Syndrome
KMTC -	Kenya Medical Training College

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First and foremost special thanks go to my research project supervisor, Mr. Jackson Maalu for not only providing invaluable and able guidance throughout the study, but also having been my inspiration in the choice of taking this particular study of strategic change management. His knowledge of the subject matter enabled me to shape this project to what it is now. My sincere gratitude to Karaine, deputy chief administrative officer (KNH), and staff of planning department (KNH), who provided most of the data used in this project. My thanks to Kenyatta National Hospital management for sponsoring my MBA studies.

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## ABSTRACT

The Public Health Institutions have not been spared the environmental changes. Through the process of strategic change, public health institutions seek to reposition themselves in order to create new competences and capacities to exploit and deal with new situations. In the late 1980s Kenyatta National Hospital experienced several challenges including major resource constraints while the demands for its services were increasing. This presented a challenge to the hospital management in seeking for best ways possible of sustaining quality health services within the framework of decreasing revenue from the central government. As a result the hospital had to adopt strategic change in order to survive in the Kenyan economy, which has not been doing well in the last ten years. It is against this background and the struggle by the referral hospital to stay afloat that this study undertook to analyze the change effort at the referral hospital. The study sought to establish the strategic change management practices of the referral hospital and the factors that are influencing the change management practices. The study was conducted by carrying out in-depth interview with senior heads of departments at the hospital.

The study came up with a number of findings: First the findings on what was the force behind the need for change are consistent with the literature by Hill and Jones (2001) who see the primary purpose of strategy as aligning the management of an organization with changes in the environment. Public dissatisfaction with declining service quality exerted pressure on the referral hospital to change and respond appropriately, with a view of rendering it more efficient and effective in the delivery of health services. Second, the change management process indicates attempts by the referral hospital to apply change

management models proposed by various change experts. A vision was crafted, strategies developed, separating from the past by re-designing the hospital symbols of the Logo and flag to capture new hospital image envisioned by the mission statement, teams were established and legitimacy and political support was mobilized.

The study revealed that several factors negatively affected the change process. Resistance (both behavioral and systemic), individual resistance was posed mainly by clinicians who for example resented the recruitment of an expatriate Mr. Bob Wilcox to manage change on high salaries without adequate consultation, unsupportive cultural practices, inappropriate leadership, poor teamwork and low commitment to the change combined to slow down the change process. Improved quality at the hospital together with declining quality of city clinics led to even higher congestion at the hospital. The hospital changes invested heavily in improved infrastructure and equipment, which contributed to additional recurrent costs.

Despite the constraints, change at the referral hospital made considerable gains. The reform effort has enabled the hospital improve on the quality of care, cleanliness, efficiency, effectiveness, and quality customer care while improving greatly the staff morale. It has enabled the hospital retain highly skilled medical specialists within easy reach at all times and has resulted to improvement of public relations between the referral hospital and other partners both in the private and public sector. Lastly, hospitals have an important role in the health care system and need to embrace rapid change in order to play their correct role in the changing scene of health care.

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# CHAPTER ONE: INTRODUCTION

## 1.1 Background

The global economic situation has changed drastically for the worse since 1977 when the goal of health for all was adopted. The past eight years have been the worst turbulent times for the world economy in over a half a century. The recession has had important implications for adjustment policies, which Governments have had to adopt in order to maintain a reasonable balance between economic growth and social development. This has not been an easy task for majority of the developing countries, especially the poorest countries of the world. The health budgets of many countries have been severely reduced at a time when additional resources are required to build and sustain national health systems based on primary health care to meet the priority health needs of all people especially the vulnerable and underserved. Whether because of economic, technological or social factors, organizations are faced with a period of rapid and unprecedented changes (WHO, 1995).

Rose and Lawton (1999) note that change has become an enduring feature of organizational life. They observe that few people if any, currently in the public, private, or voluntary sectors can claim to have been untouched by either the pace or direction of organizational change in recent years. In practice, the declining economic fortunes of many countries and the resultant decrease in governmental economic support for health services, plus, in some countries, the rapid escalation of costs in the health sector, led many countries to implement change practices. Johnson and Schools (1999) agree and argue that managers whether in the private or public sector are finding it difficult to make

sense of business environment in which they operate. One of the reasons for this is the speed of change. Organizations must keep changing to create short-term advantages.

Health sector reform is not a new development; it has been occurring in many parts of the world for many years. Proposals for such change tend to focus on achieving one, some, or all of the following: improved health status and client satisfaction; improved technical and locative efficiency; and improved equity of access to care. Because of the economic pressures on health systems, reform efforts in many countries have focused on financing through such measures as user charges and health insurance. In addition, countries have begun to reconsider the appropriate organization of services and the role of government in the health system. Thus, organizational changes, such as decentralization, private practice in public hospitals, and the public purchase of privately delivered services via contracting arrangements, are also underway in many countries. In developing countries, contracting most commonly occurs for the non-clinical services of public hospitals in large urban areas. For example, hospital laundry services are contracted to private suppliers in India and Zimbabwe. The principal referral hospital in Uganda contracts out staff catering, elevator services, and management and maintenance of steam and boiler services (Mills, 1994).

Kenya's health system has expanded rapidly over the past two and a half decades. The public sub-sector is essentially three-tiered. At the apex is Keynote National Hospital followed by the provincial hospitals, which deliver tertiary care and serve as referral points. At the secondary level, district and sub-district hospital provide both inpatient and

outpatients services and are referral point for the primary-level rural and municipal health centers and dispensaries. In some areas, services have been extended to the community level through the training and deployment of village health workers. In addition to general wards, district and provincial hospitals have established private wards to tap the private and self-funded market. However, there is a general concern in our country that the available health resources are not being used most effectively or efficiently. A large share of health resources is wasted because of managerial practices and use of inappropriate technologies or human resources (GOK, 1995).

Public health institution changes require a deliberate policy on the part of the institution to improve performance. Change efforts in many health institutions have suffered because potentially beneficial policies were implemented without the institution capability of supporting and managing them. Rose and Lawton (1999) advance the view that managers responsible for shaping and implementing changes to the structures, culture, or management of the organization find that the management of change represents a particular challenge and is one which requires the individuals involved to demonstrate a high degree of skills and sensitivity in dealing with colleagues if the process is to be managed successfully.

Change management, whether in the private or public sector is a daunting and often an elusive exercise. Strebel (1995) estimates that only between 20 percent to 50 percent of the organizations that set out to make radical change report success. In Zimbabwe, for example, the benefits from contracting out public hospital laundry services were limited

because performance expectations were not clearly indicated in the contracts, and there were no provisions for sanctions for poor performance. In many cases, obtaining the desired benefits of contracting required the substantial expense of retraining staff and reorganizing systems (Mills, 1994). There has to be both bureaucratic assent and political will for changes to be successful because the proposed changes may often cause civil servants feel threatened. Support for change from top management and professional staff is essential and should be encouraged.

Two approaches to successful change management have been advanced by change experts; the planned approach and the emergent approach. It has been argued that the planned approach works best in stable and predictable environments while the emergent approach work best under turbulent environments. However, it has been observed that organizations face a continuum of change circumstances ranging from stable to turbulent with varying level of turbulence in between. Such situations may not be best handled by either planned or emergent approach. There needs to be an approach that is contingent and adaptive to different circumstances (Burnes, 2000).

Practitioners, academicians and writers have established different models for leading change successfully. These models if properly applied, they argue, should see change through successfully. However, even with all these approaches and models of change management, change programmes still report dismal performance.

## 1.2 History, Role and Status of Kenyatta National Hospital

It is noted in the KNH centenary report (2001) that KNH was established in 1901 with 45 beds and was called the Native Hospital. It was located at the junction of government road and kings way (present day university way). In 1922, the in-patient services were consequently relocated to a vacated military hospital (number 87 opposite Buller military camp) originally built to take care of the Kings African Rifles personnel during the First World War. In 1927, there were deliberations regarding the establishment of a group-combined hospital for the African and Indian communities.

The Nairobi group hospital scheme kicked off in 1937 when the first foundation stone was laid for the medical block for the Africans. The African wing consisting of medical and surgical wings was the first to construct. The medical block was completed and opened on March 1947, by Sir Philip Mitchell, the then Governor of Kenya. The surgical block and the Asian wing were completed and opened on February 1951 by the Countess Mount Battern of Burma who was the superintendent-in-chief of the St. John Ambulance Brigade. The Asian wing was thus named Ismail Rahimtullah wing. The wing now services as KNH staff Training Centre.

The need to change the name group hospital was expressed by the Director of medical and sanitary services who felt that, "that group hospital name is no longer strictly appropriate as the group hospital was originally intended to be a hospital containing the three-races. As now envisaged, it will be a hospital containing wings of Africans and Indians. The European wing is to be built elsewhere". Permission was sought from the

colonial office in London to change the name to King George Hospital. On April 1964, King George Hospital was renamed Kenyatta National Hospital in honor of the first president of Kenya, H.E the late Mzee Jomo Kenyatta.

As the largest and most visible public hospital, and the single entity consuming the largest share of the Ministry of Health budget, a new approach to the management of the Hospital was needed to serve as the model for the rest of the public sector. In April 1987, a presidential order established Kenyatta National Hospital as a state corporation. As a parastatal, KNH's management and organization structure is aligned to its specific requirements and similar to those of large private sector organizations with a Board to which management reports and senior management positions responsible for the main functional areas of Hospital services and administration.

In November 1991, the government tried the services of a team of expatriates, the International Hospital Group, to manage the Hospital with the aim of improving the administrative skills of the local staff. A British expatriate, Mr. Bob Wilcox, took over the running of the Hospital as the chief Executive following the signing of a 3-year contract between the government and the International Hospital Group of the United Kingdom. The then Director, Dr. Agata, acted as a counterpart to Mr. Wilcox. However, this arrangement did not last long. On hindsight, local clinicians resented the recruitment of the expatriates on high salaries without adequate consultations. The expatriate team was rejected. Consequently, in 1992, the team was replaced by Prof. Julius Meme, who assumed overall authority of the Hospital (KNH, centenary report, 2001).

KNH has at present over 5,000 full time employees. In the 1960s the development of staff was mainly focused on training of doctors. In the later years as the number of staff in various cadres began to rise, KNH embarked on continuous staff training programmes aimed at developing an efficient workforce at all levels. This has gone a long way in making the staff more effective and productive in the various service areas.

In an effort to boost its financial base, KNH opened amenity wards, which today form a fully-fledged Private wing. The private wing aims at providing quality health care at an affordable cost and retaining most of the professional staff within reach while doing their private practice within the hospital. The private wing has enabled the hospital to improve the quality of care, cleanliness, and efficiency and has improved staff morale. The wing's quality of services is comparable to that of its competitors in the private sector, which has led to an increased demand for beds. Several institutions have requested for credit facilities for their staff. This has led to an increase in revenue generation.



### 1.3 Statement of the problem

The vision of Kenyatta National Hospital is to be a regional center of excellence in the provision of specialized services in all areas of healthcare. However, dwindling government funding to state corporations in the late 1990s constrained the hospital ability to deliver sustainable quality care to all. This presented a challenge to the hospital management in seeking for best ways possible of sustaining quality health services within the framework of decreasing revenue from the central government. In addressing the challenges, there was an urgency to expand private practice to assist the hospital in generating more resources for the increasing number of patients (KNH, 2001). A development of widespread concern is the management of private practice within this public institution. The objective of this private practice is to provide an incentive for high quality medical staff to see and treat their patients on the KNH premises and thus ensure their continuous presence and to generate a profit to finance services of the general public hospital.

There appears to be a general recognition that the hospital is pursuing two conflicting objectives as it strives to sustain the highest standards of medical care. The last two objectives imply that the hospital will try to focus more on private patients at the expense of the general public patients. This may result to the hospital management being out of tune with the needs of the public patients that they are intended to serve. There are therefore those who view this private concept with suspicion. They argue that it reduces access to quality health services to the poor and favors those who are able to pay, thus deviating the hospital from its objective of striving to sustain the highest standards of

medical care through continuous clinical audits and review of patient management practices (Mills, 1994). There is clearly a need for some hard thinking about whether, in pursuing conflicting objectives, the hospital can be able to realize its corporate mission of providing quality healthcare services in East Africa and beyond. In light of this development, it is important for a study to be carried out to determine how Kenya's largest referral hospital is coping with this change practices and start to develop a body of knowledge on the management of strategic change practices in public health institutions.

Several studies have been done in Kenya on strategic change management practices in various sectors in the business environment. Gekonge (1999) looked at strategic change management practices on quoted companies at the Nairobi stock exchange. He concludes that culture affects greatly the management of strategic change process. His results further revealed that the main challenges of managing change in most Kenyan companies were resistance by employees to change. In his paper on strategic change management practices in Kenya, a case of Nairobi bottlers. Rukunga (2003) found that Nairobi bottlers followed one of the known models of strategic change management in their change program but did not give the necessary weight to one of the steps of the model.

Mbogo (2003) concluded that the application of "Management by projects" was the main organizational tool applied by Kenya commercial bank to turn strategy into reality and to manage the change programme. The main achievements for the change effort were enhanced customer appreciation and internal communication. The main factor that adversely affected the change effort was a non-supportive organization culture. Ogwora

(2003) looked at strategic change management at NCPB. He concluded that the highest force pressuring change was the need to plan ahead but reinforcement of the change was found to have been very poor.

As can be seen, there is no particular study that looks at the management of strategic change practices in public health institutions. There therefore exists a knowledge gap in this area, which the study seeks to address. The study focuses on the strategic change practices at Kenya's largest referral hospital. How is Kenyatta National Hospital coping with this change practices? What are the factors that are influencing the change management practices at the referral hospital?

#### **1.4 Objectives of the study**

The objectives of the study were the following:-

- a) To establish the strategic change management practices of Kenyatta National Hospital.
- b) To establish the factors that are influencing the change management practices.

#### **1.5 Importance of the study**

Every country requires a vibrant, functioning and efficient healthcare sector. Hospitals are an important part of any health system. The study will be important to the following groups of users.

- 1) The academia may use the findings for further research in the area of change management and in particular the practices that will contribute to successful

strategic change management in public health institutions. Practitioners may apply lessons learnt in planning and implementing future changes in similar organizations such as Moi referral teaching hospital.

- 2) Health Administrators. This study will be available to health administrators to enable them identify the most appropriate strategic change management practices needed to successfully manage strategic change.
- 3) The study will also benefit Management of KNH, as it will be a source of information regarding management of strategic change. In addition the findings will be important to employees in understanding the dilemma that challenge management in implementing change initiatives. They will also have an opportunity to gauge the progress and direction of the change effort.
- 4) The Kenya government will be able to refer to the study findings in developing appropriate change management practices in public health institutions.

## 2.2 Strategic Management

Strategic management is a subject that has become increasingly important for businesses as they try to survive and thrive in an increasingly dynamic environment, which is filled with ambiguities and uncertainties, and where new information, general uncertainty or externally can create a different perspective on original strategies. Originally it was called business policy but now encompasses more than planning. Chandler (1962) defines strategic management as the determination of the basic long-term goals and objectives, adoption of the courses of action and allocation of resources necessary for carrying out these goals.

## CHAPTER TWO: LITERATURE REVIEW

### 2.1 Introduction

This chapter starts with a review of the concept of strategic management which will enable us place the subject of our research in the right perspective. Because implementation of strategic change has been difficult to manage, various scholars, writers and practitioners have proposed change management approaches, processes and models. These are presented in section two together with some criticisms to their universal application. The next section explores the context of management-public/private sector debate. Though the public sector is somewhat unique as will be demonstrated in this section, it too does respond to the environmental changes through the process of strategic change management. The last section discusses the factors that have been identified as influencing the change management practices.

### 2.2 Strategic Management

Strategic management is a subject that has become increasingly important for businesses as they try to survive and thrive in an increasingly dynamic environment, which is filled with ambiguities and uncertainties, and where new information, generated internally or externally can create a different perspective on original strategies. Originally it was called business policy but now encompasses long-range planning. Chandler (1962) defines strategic management as the determination of the basic long-term goals and objectives, adoption of the courses of action and allocation of resources necessary for carrying out these goals.

Johnson and Scholes (1999) state that strategy is the direction and scope of the organization over the long-term, which achieves advantages for the organization through its configuration of resources within the changing environment to meet the needs of the market and fulfill stakeholders expectations. The organizational environment is always changing and for an organization to enhance its competitive advantage, it must configure its resources to match the changes. The changes could be mild or turbulent but they must be matched accordingly by appropriate strategy.

Pearce and Robinson (1997) define strategy as large scale, future oriented plans for interacting with competitive environment to achieve company objectives. It is the company's 'game plan'. While it does not detail all future development of resources, it provides the framework for managerial decisions. A strategy reflects a company's awareness of how, where and when it should compete and for what purposes it should compete. The underlying issue of this definition is that the main thrust of strategy is to achieve long term sustainable advantage over the other competitors of the organization in every business in which it participates. It recognizes that competitive advantage results from a thorough understanding of the external forces that impact on the organization.

Ansoff (1965) defines strategy as the product market scope of a company. This refers to a decision of what to produce in what market. If the environment is stable, an organization can operate without changing its product-market focus. However, if the environment changes, this would require changes in the organization's product

market focus that is, its strategy. Product market focus relates to conditions of the external environment which have to be incorporated into strategy. If the products the company is producing or the markets it is serving are not reflective of the demands of the external environment, then the company's efforts are futile.

Mintzberg (1991) offers five definitions of strategy: strategy as a plan (intended) or a guide or course of action into the future, a ploy or a manoeuvre intended to outwit rivals in a competitive situation, a pattern realized or consistency in behavior over time, strategy as a position or the creation of a unique and valuable position involving a different set of activities. Yet to others strategy is a perspective namely an organization's fundamental way of doing things.

Aosa (1992) states that strategy is creating a fit between the external characteristics and the internal conditions of an organization to solve a strategic problem. The strategic problem is mismatch between the internal characteristics of an organization and its external environment. The matching is achieved through development of organization's core capabilities that are correlated to the external environment well enough to enable the exploitation of opportunities existing in the external environment and to minimize the impact of threats from the external environment. Strategy is therefore required in order for an organization to obtain viable match between external capabilities. It must also continuously and actively adapt the organization to meet the demands of an ever changing environment.

From the discussion above we note how inter-related the organization and their external environments are, as this is where the organization's outputs are discharged and where inputs come from. We also note that the company must discharge those outputs that meet the needs of the external environment. This external environment is always changing, sometimes more turbulently than other times. Consequently, the company must not only configure its resources to meet these needs but must develop foresight, flexibility and speed in order to respond to these changes in a timely manner. For an organization to be able to interact effectively with its external environment, it must have a strategy and be able to manage this strategy.

### **2.3 Models of Strategic Change Management**

Experts have proposed various approaches to change management. Predominant among these are the Planned and the Emergent approach. The planned approach which has been popular till the 1980s view organizational change as a process of moving an organization from one fixed state to another through a series of pre-planned steps. The three-step model by Kurt Lewin proposes that permanent change in behavior and system within the organization involves unfreezing previous behavior, changing and freezing new patterns. Central to the planned change is the stress placed on the collaborative nature of change effort; the organization, managers and consultants jointly diagnose problems and plan and design the implementation of specific change (Burnes, 2000). The Emergent approach views change as a continuous open-ended and unpredictable process of aligning and realigning an organization to its changing environment. The approach recognizes the importance of



the organization to adapt to the changing external conditions making it suitable to turbulent environments. A major development in the emergent approach is its emphasis on bottom-up approach to change. This is because the pace of organizational change is so rapid and complex that it is impossible for a small number of senior managers to effectively identify, plan and implement necessary organizational responses (Burnes, 2000).

Kanter et al (1992), on their part give what they call the Ten Commandments to executing change successfully. Analyzing the organization and need for change; creating a shared vision and a common direction; separating from the past; creating a sense of urgency; supporting a stronger leader role; lining up political support; crafting an implementation plan; developing an enabling structure; communicating, involving people and being honest; and reinforcing and institutionalizing changes are their prescriptions for successful change.

Kotter (1997) suggests eight steps model in which he says if implemented systematically, one step after another, will lead to successful change. This practice in change management consists of the following stages; establishing a sense of urgency; creating the guiding coalition; developing a vision and strategy; communicating the change vision; empowering employees for broad based action; generating short-term wins, consolidating gains and producing more change; and anchoring new approaches in the culture. Kotter (1996) further summarized his experience of more than 100 companies trying to make fundamental change in order to cope with the environment

thus “a few of these have been utter failures. Most fall somewhere in between, with a distinct tilt towards the lower end of the scale”.

Ansoff (1988) recommends four approaches to managing discontinuous change, which are the Coercive method, the Adaptive method, the Crisis method, and the managed resistance method. The coercive method is applicable where there is high urgency. It has the advantage of speed but has shortcoming of being highly resisted. Adaptive method is applicable where there is low urgency. Its main advantage is low resistance but the method is very slow. Crisis management method is applicable where there is threat for survival. Its advantage is low resistance but has shortcoming of extreme pressure and risk of failure. The managed resistance is applicable under conditions of moderate urgency. Planning and implementation are done together. It has the advantage of low resistance because it is tailored to time capability change. The disadvantage is that it is more complex than other three approaches.

Rose & Lawton (1999), on the other hand have proposed a model for public sector change management. They propose a dozen action steps to managing change in the public sector; Assuring the support of stakeholders; using leadership to generate support for change; using symbols and language to stress the importance of change; building in stability to reduce uncertainty and anxiety; surfacing dissatisfaction with the present state to demonstrate the need for change; participation in change to build ownership; rewarding behavior in support for change; making time and opportunity to disengage from the present state; developing and communicating a clear vision of the

future; using multiple and consistent leverage points; developing organizational arrangements for the transition and building in feedback mechanisms.

According to Burnes (2000) the models that resulted from the work of other writers include; the champion of change model, which suggests that change, is likely to be lasting or to be successful or even take place at all, unless there is a change leader. The leader must provide inspiration, must have the complete or wholehearted support of senior management group and must have the authority to carry out the change. He leads the people in the change process until change has taken place and disengages himself after empowering those involved in the change process, through involvement, to continue with the change.

The Processual Model which is the temporal approach to change management. Temporal aspect of change is used as a means of breaking down the complex process of organizational change into manageable portions. It identifies the substance of change as new technology or new management techniques, the need for change is conceptualized, transition in terms of new tasks, activities and decision is achieved in the contextual framework of politics of change, human resources, administrative structures and the business market and lastly the operation of the new organizational arrangements.

The Logical Incrementalism Model in which change takes place incrementally by developing the patterns of change incrementally. This includes creating awareness

and commitment incrementally; amplify understanding and awareness; legitimizing new view points; making tactical shifts and partial solutions; broadening political support and overcoming opposition zones. Then solidifying process in the change programme incrementally by; creating pockets of commitment; focusing the organization; managing conditions and formalizing commitment by empowering champions. Lastly integration of the process and interests in the change programme.

No two approaches to change appear to be exactly the same and in some cases they almost entirely contradict each other. Many managers often think that their job is to implement the particular approach to strategy and change which specialists recommend, or which other more successful organizations have adopted. Burnes (2000) argues that though most experts would claim some sort of universal applicability for their favored approach or theory, the reality is that such approaches are developed in particular circumstances, at particular times often with particular types of organization in mind. Change experts propose that a successful change process involve three stages; Preparing for change, beginning the change and cementing the change. At the preparation phase, the need for change is established and what is to change is identified. At the beginning phase, the strategies for change levers are determined. At the cementing phase, attempts are made to ensure that all are involved in the change.

Kanter et al (1992) proposes and explains the need for strategic change is therefore, to create a change adept organization that anticipates, creates and responds effectively to

change. Organizations that embed change capabilities in everyday operations and empower stakeholders to serve as agents of change are less likely to be blindsided by surprises due to highly turbulent environment or to face resistance from the stakeholders. Therefore organizations should aim at attaining these levels in their strategic change process.

For the purpose of this study, management of strategic change is; therefore, how to create the conditions that make proactive change a natural way of life (Kanter, 1992). This aims at developing a change adept organization that anticipates, creates and responds effectively to change in the external and internal environments to increase profit potential of an organization.

## **2.4 Context of Management-public/private sector debate.**

Health care wants and desires are limitless but the resources to satisfy these wants are not. Scarcity is the imbalance between the desire for goods and services and the means to satisfy them. Scarcity is a universal problem faced by poor and rich nations alike. Health care is an excludable public good. It can be priced easily and can be produced and sold at a fee. It has therefore been possible for private firms to provide the service for a fee, for government to finance the service through taxes and provide services for free, for government to levy fees through cost sharing or for government to subsidise private firms so as to reduce the price and encourage consumption. While the private hospitals are competing for clients with the purchasing power to pay for their services, the public hospitals cannot cope with the demand.

According to WHO annual report (1995), public/private sector collaborative working have increasingly become a key option for tackling and responding to the growing demand for social services in many countries. This is particularly the case where scarcity and competition for public resources makes it difficult for governments to increase their allocations to the social sectors. Moreover, there is a growing worldwide recognition that the state alone cannot sufficiently provide the necessary resources to meet the complex demands of the changing health needs of the population.

Many governments in Africa have recognized the positive contribution made by the private sector in the development of the country. This recognition has translated into the formulation of national policies aimed at promotion of private investment in all economic sectors. The scope of private participation includes sectors once thought to be mainly in the public domain such as health and education. Whilst the government through MOH and other related ministries remains the main provider of health care services, private health care providers have made significant inroads especially in the bigger towns. The increasing prominence of the private health care sector has, in part, been a response to public demands for better quality and quantity of health care (Mills, 1994).

- There does exist an argument as to whether the public sector is distinct or unique in its management practices from those practiced in the private sector. One school of thought argues that there is a difference. Firstly, they argue, public services have

distinctive purposes, conditions and tasks different from those in private sector. Second, they point out that in the private sector, equity is determined by the market, while in public sector needs are the issues. Third, decisions facing public sector management are different from those in the private sector. Fourth, public service organizations have complex, diverse and often-competing objectives unlike in the private sector. Those who say that there is no major distinctiveness, point out that the scientific management models developed by Taylor and Weber apply equally well in both private and public sector organizations (Rose & Lawton, 1999). In any case, they add, current trends show that the public sector organizations are being influenced heavily by the private sector management practices.

Political, economic, social and technological changes do affect the public sector organizations. Political parties after elections come with new government policies calling for changes in public sector structures in order to cope with new programmes. Changes in the structure of the economy because of globalization require changes in the public sector to address emerging issues. Demographic and social-cultural changes bring new demands on delivery of public service including health, education and social security. Technological changes require the public sector to reorient its staff to cope with new demands.

According to WHO annual report (1995), the South African public health sector faces a number of challenges in the struggle to provide more equitable access to health care. Disadvantaged communities need greater access to good quality services, but

given government budget constraints, this can only happen if additional resources are generated and if resources are used efficiently. As a result of declining public hospital standards, private hospitals have proliferated and thrived, draining doctors, patients, and income from the public sector. As one of its strategies to address these issues, the government has determined that greater integration public and private sector services can help make better use of available health care resources. Proposals include the establishment of private practice to facilitate private sector use of under-utilized public hospital resources, with the anticipated benefits of reducing the overall cost of care, and generating additional revenue for the public hospital, which can be used to improve services for public patients.

Public hospitals must be able to provide satisfactory and efficient services, and some investment will probably be needed to make them more acceptable to private patients. The hallmarks of the new management approach should be open but disciplined communication, team working, strong corporate, including financial accountability and loyalty, and an action centred approach to performance. These are some of the telltale characteristics of a well-run public hospital. It must also be stressed however that the management process is only a means to an end- better patient care- not an end in itself. But better management will lead to better institutional performance and the rewards which come with it are potentially great: better services with less waste, better value for money, more satisfied patients and a more fulfilled staff.



## 2.5 The Public Health Institutions and Change Management 115 based

### **Decentralization.** part of the broad policy framework of the ministry of health, there

There is a wide range of organizational changes taking place in health system throughout the world. Some focus on decentralization. Decentralization can be defined as the transfer of authority, or dispersal of power, in public planning, management and decision making from the national levels, or more generally from higher to lower levels of government. Influenced by lessons learned from the change practices applied in other sectors, some policy makers have concluded that the performance problems of public hospitals were similarly grounded in the rigidity of hierarchical bureaucracies, the lack of control by managers over day-to-day operations of facilities (Mills, 1994). create a great deal of confusion about lines of

Many countries are adopting decentralization policies for the health institutions with high expectations of the benefits to follow. However, it is important to note that the impetus for decentralization has come from different directions. Firstly, there are those analysts who see decentralization as an important tool for implementing primary health care policies. In this case it is a means of empowering local communities, improving multisectoral coordination of activities at the local level and stimulating participatory planning that is more responsive to local demand. More recently, decentralization has also been promoted by bodies such as the World Bank as a means of improving the efficiency, management, and responsiveness of government health services (Green, 1992). of non-clinical services have proved

Kenya's public health sector has not fully gone through decentralization in its broad sense. However, as part of the broad policy framework of the ministry of health, there are intents towards the decentralization of the health sector to promote efficiency and accountability at the grassroots. In this respect, decentralization can cut red tape, and as a result make the central government and health administration increasingly flexible, accountable and responsive. In the end, it would take resources and decision-making close to the people, improve the link between supply and demand and services and activate mobilization of resources on the local level (GOK, 1995).

It is not always easy to design decentralized health sector changes that achieve the desired effects. Decentralization can create a great deal of confusion about lines of authority and lines of accountability. This is particularly the case when only some functions are decentralized but others remain under the control of the original ministry. For example if decisions on resource allocation have been decentralized to local authorities, but health care staff are still paid for and employed by the ministry of health, to whom are staff answerable? Should it be the local authority, which is trying to manage the health care services or its paymasters in the ministry of health? Decentralization in Ghana caused an increase in health sector costs and exacerbated rather than reduced regional inequality (Green, 1992).

### **Contracting of publicly provided services.**

The use of government funds to buy clinical or non-clinical services from private provider is a practice generally intended to increase the productivity of public

resources by purchasing gains in efficiency perceived to exist in the private sector. Service contracting is primarily a strategy to improve the quality or increase the quantity of services that can be made available for a given amount of government expenditure. Competition of contracts among potential providers should yield improvements in efficiency on the supply side. The change from direct provision of services to contractual arrangements should enhance efficiency through an increase in the transparency of accounting practices (Mills, 1994).

In developing countries, contracting most commonly occurs for the non-clinical services of public hospitals in large urban areas. For example, hospital laundry services are contracted to private suppliers in India, Mexico, Thailand, and Zimbabwe. Cleaning services and canteens are contracted out in many Mexican public hospitals, and contracts are also used for the maintenance of some high-tech equipment. The principal referral hospital in Uganda contracts out staff catering, elevator services, and management and maintenance of steam and boiler systems. Contracting may also be a way for government health authorities to circumvent corruption as well as civil service obstacles (Mills, 1994).

As Mills (1994) points out, however, there has been very little assessment of the success of these change practices with regard to progress on health objectives. The limited evidence to date is not the product of systematic study but rather of anecdotal reports. For example, the cleaning and portering services of three Jamaican public hospitals were contracted to private providers, beginning in the late 1987. The quality

of these services has reportedly improved at a cost of about half the previous budget. Contracting out catering, cleaning and security services at a large Tunisian public hospital has also yielded improved quality at similar or lower cost.

Introducing contracts for services formerly provided directly by health institutions implies a change in the role and function of the latter. This would mean retraining civil servants to act as contract managers and possibly also restructuring the institutions. To ensure gains in efficiency from contracting services to private providers, public health institution managers of contracts would need to have the skills to establish contracts, evaluate bids, and monitor contractor performance. Because the concept of efficiency includes outputs as well as costs, the skills needed for efficient contracting include the capacity to specify performance criteria and monitor progress, imposing sanctions as necessary to ensure compliance.

#### **User charges for publicly provided services.**

Given the broad reform goals of improving efficiency, equity, consumer satisfaction, and health status, achieving a high degree of cost recovery is not, in and of itself, an objective of public health policy. User charges can, however, be useful means of advancing towards such goals as a sustainable health service of adequate quality. In public sector, therefore, cost recovery constitutes a means to an end rather than being an end in itself. Whether user charges are successful tools for enhancing health objectives depends above all on the organizational and managerial context in which they are applied (Creese, 1991). The World Bank's policy study on health financing

suggested several ways in which user charges for publicly provided health services could lead to greater efficiency in the health institutions than when services are provided free of charge. First, fees could dissuade unnecessary use of services. Second, by coordinating prices among different levels of facilities, fee systems could encourage appropriate use of first-contact and referral facilities. Third, where fees are charged in a facility, exemptions for such important services as prenatal care or tuberculosis treatment could encourage their greater use (Creese, 1991).

The potential beneficial effects of fees from the standpoint of equity are usually not realized because fees tend to dissuade the poor more than the rich from using services and income-based pricing and exemptions have proved very difficult to implement in a consistent and accurate manner. Studies in many countries, including Ghana, Peru and Zaire, as well as in Canada have shown that poorer people are more likely to be put off by price increases than richer persons are. It was argued that persons with higher incomes tend to use services more than those with lower incomes, so that the introduction of fees would reduce inequity by obliging better off persons to pay. Traveling distances, which reflect cost, both in time and money, of gaining access to a health facility, has shown similar deterrent effect (Creese, 1991).

In Kenya the initial introduction of user charges suffered from severe administrative problems, however, and, in retrospect, was too rushed. Time was not taken to prepare the public fully for cost sharing, to establish procedures for exempting those unable to pay and for authorizing health institutions to spend the 75% of fees that they were to

retain. Given this last, there was no visible improvement in quality linked to the introduction of charges. The granting of waivers on grounds of inability to pay was never publicly announced but was at the discretion of designated nurses or medical officers at each institution, after the first consultation, the patient was to be referred to the area chief to endorse an exemption form certifying hardship. Higher charges were established for all services at Kenyatta National Hospital than elsewhere in the public system, again reflecting the graduated nature of the fees (GOK, 1995).

## **2.6 Factors that influence change management practices**

Resistance, culture, stakeholder politics, teamwork and leadership have been identified as factors that can influence the outcome of any change programme.

### **i) Resistance**

According to Ansoff and McDonnell (1990), resistance to change is a multi-faceted phenomenon, which introduces delays, additional costs and instability into a change process. Resistance can either be behavioral or systemic: Behavioral resistance is exhibited by individuals, managers or groups. Because of parochial self-interests, misunderstanding and lack of trust, or low tolerance to change individuals or groups may resist change. To overcome this problem there is need for those managing change to understand the needs of employees and also for employees to understand the change plan.

Systemic resistance originates from passive incompetence in managerial capacity to carry out the change. The capacity required to implement change is normally more

than the existing capacity. Management requires planning and developing the required capability by integrating management development into the change process and stretching the implementation period as long as possible.

Leadership must drive the process of change to alter the employees' perception and bring about revised personal impacts. Without proper leadership employees will remain skeptical of the vision for change and distrustful of management and management will likewise be frustrated and stymied by employees' resistance to change (Strebel, 1995). Rose and Lawton (1999) note that if change involves challenging existing power arrangements, resistance to change is inevitable. To deal with such resistance, they propose use of some techniques, which include education and communication, participation and involvement, facilitation and support, manipulation and co-option.

## ii) **Organizational Culture**

Rowe et, al (1994) define organizational culture as the total sum shared values, attitudes, beliefs, norms, expectations and assumptions of people in the organization. Thompson and Strickland (1993) argue that there must be a fit between strategy, structure, systems, staff, skills, shared values, style for strategy implementation to be successful (Mckensey 7's framework). Thompson J (1997) argues that organizational culture and values held by managers and other employees within the organization are key influences on strategies of change and therefore central driving consideration in strategy creation and change.

Johnson and Scholes (1999) referring to culture as routines, note that such routines which given an organization a competitive advantage may act as bottlenecks when implementing changes. When planning change it is important to identify such routines and change them. Burnes (2000), however differs, according to him changing routines can be difficult. Instead the organization is restructured and people placed in new roles and relationships and new culture develops. Gekonge (1999) looked at strategic change management practices on quoted companies at Nairobi stock exchange. He concludes that culture affects greatly the management of strategic change process. His results further revealed that the main challenges of managing change in most companies were resistance by employees to change.

### iii) **Political Management, Mobilizing Support and Legitimacy**

Stakeholders' support is essential for a change programme. Because of many stakeholders groups with different interests and power, achieving universal support is a challenge and politics sets in. Hill and Jones (2001) see organizational politics as tactics that strategic managers and stakeholders engage in to obtain and use power to influence organizational goals and change strategy and structure for their own interests. In this political view of decision-making, obstacles to change are overcome and compromise, bargaining and negotiation between managers and coalitions of managers and settle conflicts over goals by the outright use of power. Kanter et al (1992) argue that the first step to implementing change is coalition building, which involves those whose involvement really matters. Specifically, stakeholders must support any change programme for it to see the light of the day.



#### **iv) Teamwork**

The complexity of most of the processes, which are operated in industry, commerce and service, place them beyond control of any individual. The only way to tackle problems concerning such processes is through the use of some form of teamwork yet building effective teams is not easy matter. Oakland (1993) define a team as a group of people with the appropriate knowledge, skills and experience who are brought together specifically by management to tackle and solve a particular problem usually on a project basis. They are cross functional and multi-disciplinary.

Rowe et al (1994) argue that team approach to change implementation removes artificial organizational barriers and encourages openness. Teams share common goals and help to focus energy by emphasizing self-control on the participants. Teams that are cohesive, that interact cooperatively with members possessing compatible personality characteristics and that are operating under mild to moderate pressure appear to be most effective.

#### **v) Leadership**

Johnson and Scholes (2001) contend that the management of change is often directly linked to role of strategic leader. Leadership is the process of influencing an organization in its efforts towards achieving an aim or goal. A leader is not necessarily someone at the top of an organization, but rather someone who is in a position to influence others. Normally change agents or change champions provide the leadership role. The leader's role includes creating vision, empowering people, building teamwork and communicating

the vision. Thompson J (1997) while stressing the importance of effective leadership in managing change give the qualities of an effective leader as being visionary, skilled, competent, delegative, motivate, analytical, persistent, enduring and flexible.

Undoubtedly, the way changes are managed, and the appropriateness of the approach adopted, have major implications for the way people experiencing change and their perception of the outcome. The institute of management (1995) study established that the managers appeared to report considerable levels of dissatisfaction with the outcome of change. The study found out that while most managers supported the case for change, many were anxious not only about the change outcome of change but also the process of change. Aosa (1996) says that there is a need to synchronize the management and implementation of change with the context, which such a change is being carried out. This is especially true within the African context where management has shown to be different. There is evidence from researchers that organizational change management is a useful tool to facilitate successful cultural transformations to ensure that the outcome of the change initiative is positive.

## CHAPTER THREE: RESEARCH METHODOLOGY

### 3.1 Introduction

This chapter details the research design used to achieve the objectives of the study, which were to establish the strategic change management practices of Kenyatta National Hospital and the factors influencing the change management practices.

### 3.2 Research Design

The research was conducted through a case study. The study was intended to bring out information regarding the nature of change management practices that were applied and the factors that influenced the change management practices at the referral hospital.

Case study designs are most appropriate when a detailed analysis of a single unit of study is desired. Case studies do provide very focused and valuable insights to phenomena that may otherwise be vaguely known or understood. Young (1960) and Kothari (1990) concur that a case study is a very powerful form of qualitative analysis that involves a careful and complete observation of a social unit be that unit a person, a family, an institution, a cultural group or even the entire community. It is a method of study that drills down rather than casts wide. The advantages of using a case study include enabling an in-depth understanding of the behaviour pattern of the concerned unit and facilitating intensive study of the concerned unit. The limitations of a case study include the danger of false industry generalization, which might be experienced due to lack of set rules to follow in the collection of information, it is time consuming, expensive and the research might be subjective. Further it is limited in its application. Despite the stated limitations, the application of open-ended questions and in-depth interviews minimized the risk of subjective responses/answers.

### 3.3 Data Collection

Both primary and secondary data was collected and used for the study. Primary data was collected from the chief executive officer through personal in- depth interview guided by open-ended questionnaire (Appendix I) developed in line with the objectives of the study. In addition a questionnaire (Appendix II) was administered to senior managers in both clinical and Administration Departments. These are heads of Departments who control the hospital resources, make policy and therefore were directly involved in management of strategic change practices.

### 3.4 Data Analysis

Data from interview and secondary sources was summarized according to study themes of: forces necessitating the change: the change content: the management process and the factors influencing the change management practices. The content analysis technique was used to analyze the data. The findings emerging from the analysis were then used to compile this report. Nachmias and Nachmias (1996) define content analysis as a technique for making inferences by systematically and objectively identifying specified characteristics of messages and using the same approach to relate trends. This approach has been used previously in a similar research paper like the one by Mbogo (2003). He argues that this method is scientific as the data collected can be developed and verified through systematic analysis. The qualitative method can be used to uncover and understand what lies behind phenomena under study. It can also be used to gain quite some fresh material even in what was thought to be unknown.

## CHAPTER FOUR: FINDINGS AND DISCUSSIONS

### 4.1 Introduction

This chapter details the findings of the research based on the analysis and interpretation of both primary and secondary data collected from various sources. The findings focus on the areas identified for the study which are; creating urgency that involves understanding the forces that are compelling the change and how the same are articulated to create a conducive environment to undertake the change; the objectives of the change as they underline the overall purpose of the change; approaches to the change; the planning and implementation process and the factors that influenced the change management practices.

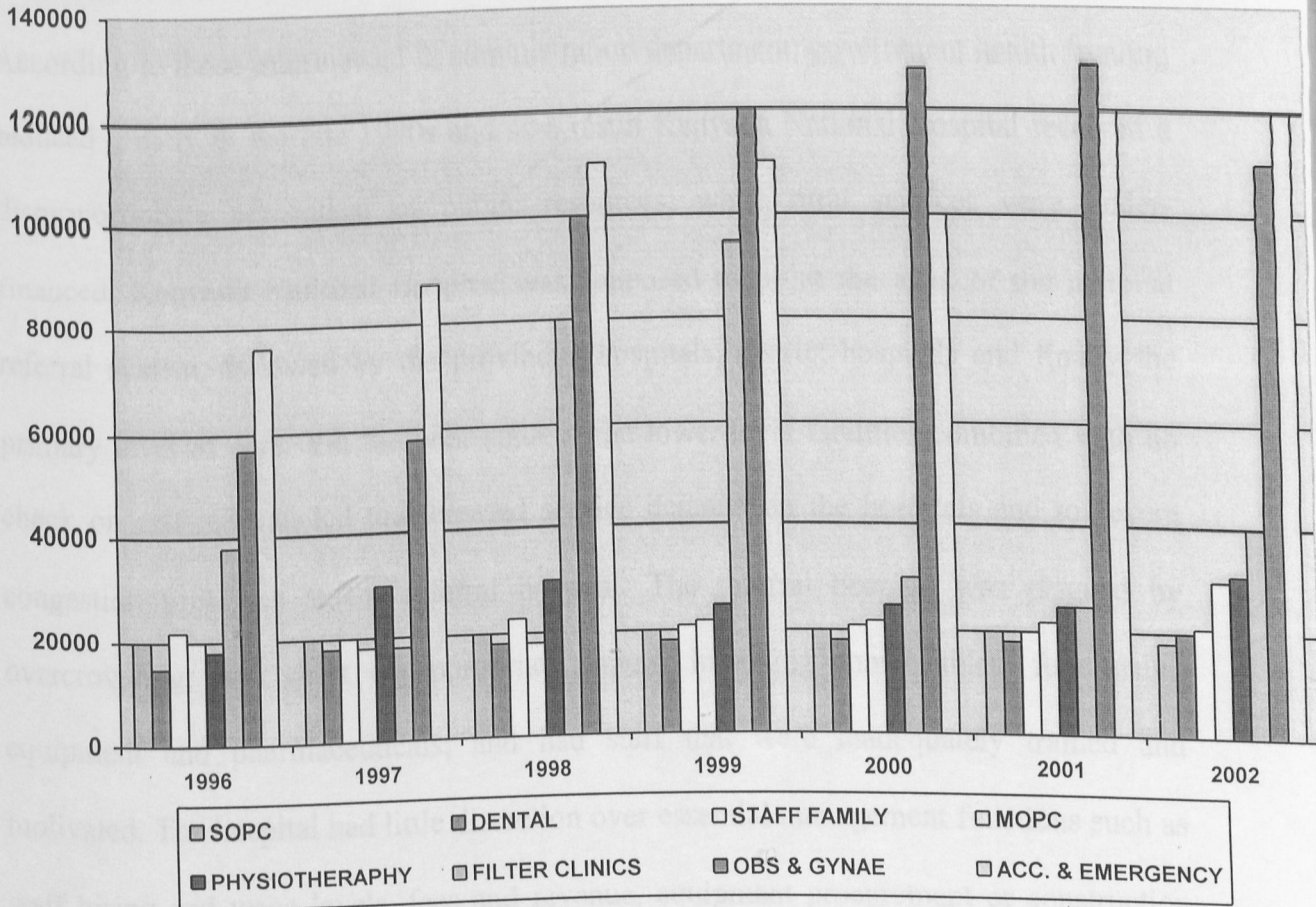
#### 4.1.1 Current Profile of KNH

The referral hospital has at present 5200 full time employees against the approved staff establishment of 6184. There are 1759 nurses and 261 doctors; others are paramedical, support and administrative staff. The hospital has not been able to attain the recommended staff: patient ratios due to the heavy patient flow. The hospital has 49 wards, 20 outpatient clinics, 24 theatres (16 specialized) and Accident & Emergency Department. Out of the total bed capacity of 1800, 225 beds are for the private wing. There is a Doctors plaza consisting of 60 suites. The average bed occupancy rate is 94% but in medical wards, the rate goes up to 300%. In addition, at any given day the hospital hosts in its wards between 2500 and 3000 patients. On average the hospital caters for over 80000 inpatients and over 500000 outpatients annually. It is the only outpatient level one trauma centre in the region. KNH offers a wide range of diagnostic services such as laboratories, radiology/imaging and endoscopy among other specialized services. It is the

second largest in Africa after the Cris Hani Baragwanath hospital of South Africa whose bed capacity is 2964.

**Graph 1: Out-patient visits by most common cause 1996-2002**

**Out-patient visits by most common cause 1996 - 2002**



Source: Hospital medical Records

#### 4.2 Forces Necessitating Change

The change practices at Kenyatta National Hospital were as a result of both external and internal factors. Externally certain social, economic, technological and political changes exerted pressure on the referral hospital to change and respond appropriately, with a view

of rendering it more efficient and effective in the delivery of health services and as a teaching and referral hospital. Internally Kenyatta National Hospital plays an important role in the healthcare system and need to embrace rapid change in order to play in the changing scene of healthcare.

#### 4.2.1 External forces

According to those interviewed in administration department, government health funding reduced greatly in the late 1990s and as a result Kenyatta National Hospital received a disproportionate percentage of public resources, while rural services were under-financed. Kenyatta National Hospital was supposed to be at the apex of the national referral system, followed by the provincial hospitals, district hospitals and finally the primary level of care. Yet the poor state of the lower-level facilities combined with no check on self-referral, led to increased service demand on the hospitals and to severe congestion problems at the referral hospital. The referral hospital was plagued by overcrowding; was short of appropriate inputs, including consumables, functioning equipment and pharmaceuticals; and had staff that were inadequately trained and motivated. The hospital had little discretion over essential management functions such as staff hiring and wage levels, fees and revenue, equipment procurement or construction and maintenance. Revenues from cost recovery were returned to the central treasury providing no incentive for improved financial performance.

Public dissatisfaction with declining service quality led to growing government recognition of the need for reforms. In 1987, the World Bank sponsored a study to review

health sector financing, in preparation for health sector reform project. The report recommended improved revenue generation, cost containment, and efficiency of service delivery through the establishment of user fees for government health services and shifting government financing towards basic health services. The report suggested that Kenyatta National Hospital was the best place to start a move toward managerial autonomy, especially planning, budgeting and fee collection. Other donors including the US. Agency for International Development (USAID), were also actively involved in policy studies and dialogue regarding reform options.

Partly as a result of this and other studies, the government of Kenya (GOK) initiated two major policy changes. First, in 1987, the government converted Kenyatta National Hospital into a parastatal corporation, which was intended to transfer much day-to-day decision making control to the hospital and oversight responsibility to a newly created Board of Directors. The hospital could retain revenues from user fees, manage its procurement and had greater latitude over hiring, firing and promotion. Second, in December, 1989, the government introduced graduated user fees for all public health facilities-a departure from its initial policy of free government services.

These changes did not have the intended results however. Despite increased autonomy, the staffs were loath to let go of the centerpiece of the public system, and the hospital Board was not prepared to take control. The hospital was unable to fill key positions especially in financial management. Because the reforms did not address problems in basic health services in Nairobi, hospital congestion increased. In addition the user policy



was not well designed or implemented, generating strong public backlash. The public was poorly informed of the need and rationale for the change and because fees were not retained at facilities, quality did not improve. Exemptions for the poor were ineffective, and service fell by nearly 50 percent. When this happens as it did in Kenya's referral hospital, there is need to change strategies and build new competence and capacities to meet the emerging demands.

### **4.3 Strategic Objectives of the Change Program**

The respondents identified the major objectives of the change as; strengthening clinical services and establish revenue generating private services by reinforcing cost sharing thus supporting increased mobilization of resources for health from sources other than general revenues; to provide an incentive for high quality medical staff to see and treat their patients on the hospital premises and thus ensure their continuous presence; securing financial sustainability and reducing the referral hospital's burden on the ministry of health recurrent budget from 14 percent downwards to allow for allocation of ministry of health resources to preventive and primary services; improve on the provision of quality health care through various clinically efficient and effective interventions through developing new mutually beneficial public and private sector partnership and lastly to maintain, update and sustaining specialized facilities for use for referral and training purposes through cooperation with college of Health sciences, University of Nairobi and the Kenya Medical Training college (KMTC).

#### 4.4 Kenyatta National Hospital Change components

According to the deputy chief administrative officer, the government initiated several changes to the rules and regulations governing the hospital and in its relation to the ministry of health. First, in 1990, Kenyatta National Hospital staff was transferred from the ministry of health to KNH, with employees given a choice during a 2-3 year transition period to decide whether to stay at the referral hospital or work at a ministry of health facility. The management board was then given discretion for hiring and firing. Second, with regard to revenue, the government gave the KNH board increased discretion to set the level of user fees (although the Ministry of Health retained approval rights) and allowed the hospital to retain fees without reducing budget transfers. Third, in 1994, partly in response to recommendations from the World Bank and USAID, the hospital funding was converted from a line item in the Ministry of Health budget to a block grant. This removed the Ministry of Health restrictions and dramatically improving the predictability of its funding flows. Since then, all funds allocated in the budget the referral hospital have been transferred directly to the hospital.

Those interviewed in administration further revealed that a number of steps were taken at senior political level in Kenya to strengthen hospital leadership. In 1992, the government appointed a respected Kenyan businessman to serve as the chairman of the hospital board, and gave him broad discretion authority to improve hospital management and performance. The president then appointed an experienced physician with strong management skills to serve as hospital Director. The new leadership succeeded in attracting experienced civil servants to fill management positions in the referral hospital.

These leadership changes coincided with the beginning of the World Bank project and proved crucial to the success of the KNH component and overall hospital reforms.

#### **4.1.1 Introduction of Private Wing**

According to the chairman private wing, the referral hospital's intention to offer quality health care to all those who seek its services cannot be gainsaid. Best intentions apart, various aspects have constrained the hospital ability to deliver sustainable quality care to all. In addressing the challenges, the hospital put into place a private wing with the aim of delivering health services on a private basis. Its objective is to generate income by operating on commercial basis. This income is meant to continuously improve its services and any excess passed over to the rest of the hospital. Currently the wing is operating according to its budget and does not receive subsidies from other operations of the hospital and it has steadily operated within a surplus.

Office space for rental to Kenyatta National Hospital/University of Nairobi consultants to see and treat private patients has been constructed under the change program. The hospital worked out appropriate rental fees. The money raised is expected to top-up the operational expenses of the entire hospital, aiming at reducing over-reliance from treasury. The private wing is now self-financing, and currently contributes 40 percent of hospital revenues. In terms of qualitative aspects, the private wing is very viable. It has enabled the hospital improve on the quality of care, cleanliness, efficiency, effectiveness and quality customer care while improving greatly the staff morale.

In 1992, the hospital's board of management resolved that all members of staff and their eligible dependants shall be admitted in the private wing instead of the general wards in the hospital. The personnel and Training manager meets this cost. The service is given and paid for by the hospital for its employees. This has been a great morale booster to hospital employees and it goes a long way in making the employees feel that they own the hospital and have a stake in its smooth running and efficient operations. However, the private wing management committee has taken sometime to make a decision on the rates of compensating radiographers, laboratory technologists, radiologists and pathologists, who are involved in providing direct services to private patients. This will in the long run affect the morale of staff involved and hence lead to poor service delivery.

Nevertheless, some of those interviewed in private wing revealed that from the analysis of the available data, the private wing is yet to demonstrate the ability to make acceptable profit. Worth noting is that the wing receives very many services from the main hospital, for which it has neither been costing nor paying for. However it has the potential of generating profits for itself and the running of the general hospital. Additional ways of generating revenues should be looked at in view of the fact that the exchequer resources directed to the hospital are slowly declining while the needs of the hospital continue to exceed these resources. It is in this area that the hospital can rely on a part from the cost sharing money to ensure that its services continue and that it does not compromise on the quality of care that it gives to the patients. It should remain the center of excellence and toward this goal the private wing has enormous role to play in terms of generating revenue. There is room for raising more revenue while minimizing costs. In future the

wing should capture all its expenditure and revenue accurately. This will form a basis of future critical and deeper analysis and profit projections.

**Table 1: Patient Statistics and ALOS for 1996/97-1998/99**

Ward	Type of Service	1996/97		1997/98		1998/99	
		PTS	ALOS	PTS	ALOS	PTS	ALOS
1C	Maternity	-	-	490	4.7	7,026	4.8
9A	Paediatric						
9B	Medical (F&M)	-	-	1,433	21.1	9,397	17.4
9C	Surgical (F&M)	-	-	-	-	9,397	17.4
10A	Male Surgical	8,245	18.8	8,021	20.4	9,125	13.7
10B	Female Surgical	7,661	13.2	7,538	11.6	9,125	10.5
10C	Female Medical	7,287	17.9	7,019	16.0	8,395	14.0
10D	Male Medical	7,963	18.0	7,848	18.5	9,125	14.4
<b>TOTAL</b>		<b>31,156</b>	<b>16.1</b>	<b>32,349</b>	<b>14.7</b>	<b>60,099</b>	<b>12.1</b>

Source: Hospital Revenue Records

**Table 2: Revenue From 1992/93-1997/98**

FINANCIAL YEAR	AVERAGE NO. OF BEDS	NO. OF PATIENTS	REVENUE	% CHANGE
1992/93	48	6,667	7,422,178.6	-
1993/94	48	10,922	15,071,977.6	103
1994/95	98	18,159	23,827,694.2	58
1995/96	98	25,481	48,998,287	106
1996/97	98	31,156	88,920,284.7	82
1997/98	160	32,349	130,297,644.85	47
1998/99	184	45,320	230,000,000	14

Source: Hospital Revenue Records

#### 4.4.2 Use of Symbols, Patterns and Settings

The Logo of Kenyatta National Hospital is a visual representation of the founding ideology of the referral hospital. It reflects the functions of creating consciousness, prevention and combative measures that make a healthy nation. Bearing in mind the major functions of the hospital, that is receiving referral patients from within and outside Kenya, facilitating medical education for the university of Nairobi, carrying out medical research projects, training nurses and other health allied professionals and participation in national health programmes, the hospital's Logo had lost track to its international recognition as one of the best centers of excellence in this area. Coupled with her historical and locational founding, the Lion is usually brought in to represent both the country-Kenya, and also represent the surety and positiveness in which the referral hospital bears her task.

The deputy chief administrative officer revealed that in March 1997, Kenyatta National Hospital through the Director Prof. Julius Meme, proposed to re-design the hospital symbols of the Logo and flag to revitalize the image of the hospital to reflect its status in the country's health care delivery system. Departments, sections and units met to review each stage of the formulation of the new hospital Logo and flag. This was viewed as capturing a new hospital image and capturing the kind of referral hospital envisioned by the mission statement. In addition the seal, letterheads and envelopes were also proposed. Mr. Cephas. Y Agbemenu and Sam. A Okeyo the artists/ designers of Kenyatta University were commissioned to undertake the project of re-designing the items. There was need to break away from the past pre-conceptions about the hospital and give a clear

visible message to staff, customers/patients and other stakeholders. Following a series of consultative meeting with heads of departments and board of management of the Kenyatta National Hospital, the final designs were approved and accepted for use. The final results came about as a joint effort and decisions through consensus between the artists and the client participants of Kenyatta National Hospital. The new Logo comprises of the following component parts; a shield with upper section with two gently sloping sides meeting at the centre bottom. The shield is divided into two sections horizontally with the contents-KNH located at the upper section. The lower portion carries the Lion which holds the caduceus comprises of a central pole flanked by two wings at the top with two coiled snakes in the mid-section of the pole. ( a representation of fast medical services). The shield is supported by the scroll which ends in two dots on each end standing for belt holes. The scroll or belt carries the new hospital Motto "Quality Health Care".

**Figure 1.0 : The New Hospital Logo**



Source: Hospital Public relations records

#### 4.4.3 Personnel Management/ Training function

The other changes introduced were in the personnel and training function. In 1992, wages and benefits of the hospital staff were upgraded from civil service levels to those for parastatals. This translated to nearly a 50 percent wage increase for many cadres, which allowed the hospital to attract doctors from the university of Nairobi medical school and made nurse wages competitive with the private sector (although hiring skilled managers and computer specialists remain difficult). These changes improved the retention and motivation of staff, but also had a significant budgetary impact. Thus improvements in the terms of service and strengthened links to the university medical school increased the availability of experienced physicians at the hospital. The hospital board strengthened the role and responsibility of department heads, which improved accountability for clinical quality.

The World Bank and USAID sponsored extensive training for clinical staff most of whom returned to their posts afterwards (in part because of improvements in terms of service). The hospital introduced an on-going in-house training in the established KNH staff Training centre by those who benefited from the World Bank sponsored training. These are basically the management and clinical courses. Medical students both from the university and KMTC have benefited from the expertise currently in the hospital. The hospital members of staff report that training significantly improved clinical quality and was one of the valuable contributions of the reforms. Further the World Bank and USAID sponsored technical assistance to strengthen management systems. Specific changes included establishment of an accrual accounting system and personnel management



system, and strengthening key departments including accounting, planning and personnel. Because of staff turn-over and lack of progress in computerization some goals were not achieved.

#### **4.4.4 Quality Assurance Unit**

A vital component in the operation of a large hospital is quality control, especially where efficiency and productivity is a major issue. Only some of the clinical departments like CSSD/TSSU and laboratories had quality control activities to monitor the effectiveness and accuracy of their work. The referral hospital whose Motto is "Quality Health Care" puts a lot of emphasis on efficiency and quality control. In November, 1992, the referral hospital established the Quality Assurance unit under the auspices of the office of the Deputy Director, clinical services. The role of the unit is to monitor, analyze and improve the quality of health care and enhance efficiency in resource utilization. The design and implementation of this plan was supported by 36 months of technical assistance by the World Bank. The unit has trained various departments on Quality Assurance appreciation and has been holding several seminars. The development of a quality assurance unit is in concert with the clinical efficiency assessments that will produce recommendations concerning quality standards for all departments. An important aspect of the unit is the establishment of systematic audits of all clinical departments to determine compliance with delineated standards and to report to the Quality Assurance committee for corrective action. Further the unit has defined performance targets for each functional area which are then used to compare with actual figures at the end of each year.

#### **4.4.5 Improved Maintenance and Cost Control reforms**

In yet another change component the referral hospital developed cost containment programs both through direct reduction of some cost items and through direct improvements in clinical efficiency. The hospital adopted an energy conservation and efficiency program which has reduced fuel consumption by 23 percent in three years: future savings are estimated at 20 percent. Telephone costs resulting from abuses by the staff; have been reduced through the restriction of outside lines to employees with need. Kitchen and mortuary cold rooms have been rehabilitated to improve operating efficiency. The hospital established its own maintenance crew and trained them in hospital equipment and facilities maintenance. Supervisors are now staying at the premises at all times with the discretion and responsibility to make necessary repairs. Further, the hospital established an essential drug list and stopped providing free electricity and water to university facilities. It also introduced a workload measurement system that enables management to track unit costs and take corrective action where necessary.

#### **4.5 The Implementation Process**

The implementation of actual reforms was repeatedly delayed hence slow. The reasons were several: First, supervision of the construction of doctor's suites and private wing was weak, and several contractors performed poorly and had to be replaced. Second, procurement of equipments and supplies was problematic with several bids being canceled. The tight time schedule resulted in the procurement of some items that were more expensive, less appropriate, or had higher recurrent cost implications that might

have been procured with more careful planning. Third, weak financial management at the referral hospital led to delays in payments to contractors and suppliers. Fourth, increased fiscal constraints, together with uneven government commitment resulted in government providing only 7 percent of its expected 10 percent contribution to project costs. Staff continuity was a problem.

The hospital Director who played a role of change leader changed several times during the change implementation process. It is therefore impossible to talk of continuity of programmes of change and improvement of services in the realization of the hospital's vision and mission. The other reasons were; the hospital operational objectives were not defined; tension between the hospital's role in patient care and in teaching and research was not fully resolved; the administrative implications of the change to parastatal status were seriously underestimated; detailed implementation plans were not delineated; the personnel and office space needs of planning and implementing the changes were insufficient and inadequate at the lower level Nairobi facilities and the absence of a functioning referral system made it impossible of the referral hospital to abandon primary and secondary care to concentrate on its tertiary function.

#### **4.5.1 Consultants**

Consultants were involved in the formulation, planning, implementation, monitoring and evaluation of the change programme. Edon consultants were commissioned to assess the hospital performance, identify the problems and areas that needed changes. Consultancy studies carried out recommended improved revenue generation, cost containment and

efficiency of service delivery through the establishment of user fees for public health services. Consultants are an important input into a change programme for a number of reasons; from their diverse experiences they bring in new ideas and expertise that may be lacking in the organization. Second, they help organizations to deal with sensitive issues which are conveniently avoided by management. Third, they are in a position to view the organization from a total system point of view and they are less affected by organizational norms. However, it is always important that a reform programme is initiated and controlled by the organization. The role of the consultant should be that of a facilitator. They are helpful in accessing expertise that lack and largely facilitate the process.

#### **4.5.2 Participation/ Involvement**

Kotter (1996) avers that successful change goes beyond conventional management as is known and practiced by most managers. It involves leadership that seeks to establish direction, align peoples' aspirations, motivate and inspire the people. The research sought to know the degree of involvement amongst different levels of staff and also how the external stakeholders were involved or consulted over the changes. From those interviewed, they felt the government, board of management and hospital director were responsible for initiating the change. It is also evident from the interview that senior management were involved in coming up with the change program. This clearly shows there was a strong guiding coalition consisting of the hospital director, board of management and senior management that was responsible for guiding the change at referral hospital. The research also sought to know the enthusiasm for the change that

was evident amongst the various staff cadres. The findings indicate that there was average support for the change by both the top management and the lower staff level. Closely related to support for change is the commitment of resources to change by the hospital. The findings indicate that the management freely and willingly availed resources thus there was a greater visibility of support for the change.

### **4.5.3 Planned and Emergent Change**

The respondents were unanimous in that the change effort was planned and there is a clear line in sight to a future desired state. The approach was top-bottom where change activities were decided at the top and passed down for implementation. The hospital planned the change activities and a schedule of responsibilities and time frame drawn. Based on the consultant's study a plan of policy and institutional changes with prioritized actions and a timetable for their implementation was adopted. However, as the reform process progressed, the emergent approach started to take root. Departments were allowed to identify areas that required to be reformed and initiate the changes on a continuous basis.

The emergence of a down-up approach was encouraged with the participation of various departments in initiating reform activities. This is because change cannot be characterized as a rational series of decision making activities and events. Change is not a series of linear events within a given period of time but rather a continuous process. It is a process that unfolds through interplay of multiple variables within the organization. Therefore, handling change is part of every manager's role and not work of a specialist. The role of

the manager is not to plan and implement the change but to create and foster structures and climate, encouraging and facilitating change by the organization people.

#### **4.6 Models of Strategic Change Management and their Application in the Hospitals' Change Management Practices.**

Several change management models have been proposed by change experts. Some of these models even suggest steps that must be followed biblically in a successful change initiative. Some of these models were discussed in section 2.3 of this study report. When one looks at these models very carefully, they seem to share common features that a change management process must entail. All of them seem to agree for instance that change practices must have a shared vision and strategies that are well crafted and communicated to all stakeholders. Other common features include analyzing the need for change, creating a sense of urgency, a strong leadership, lining up political and stakeholders support, using symbols, crafting an implementation plan, developing enabling structures, communicating, involving the people and reinforcing and institutionalizing change among other features.

Change process at the referral hospital was characterized by a number of these features. The hospital re-designed the hospital symbols and logo with a view of capturing a new image thus breaking away from the past pre-conceptions. Symbols are a powerful tool in managing change. Part of the evidence gathered towards analyzing the hospital and need for change was the conduction of seminars and teambuilding workshops in-house attended by all employees at Ismail Rahimtullah wing which serves as KNH's staff

training center. These two events created in all employees mind the need and will to change. In all the cases, the change effort was led by the hospital director both present and immediate past.

The referral hospital also developed a clear vision and strategy which is critical for the success of a change program. The strategies to achieve this vision were outlined. This was communicated. Important stakeholders were mobilized to support the change initiatives. Though change process at the referral hospital did not adopt wholly any of the models of change, it nevertheless borrowed and applied the principles enshrined in most of these models. It therefore appears that the hospital selected what appeared important under the circumstances. It is argued that though the models are useful, it is incumbent upon the change managers to review the context under which changes are to be implemented and adapt the models to suit their particular circumstances. This is an important step in view of the fact that different circumstances will need specific attention.

#### **4.7 Factors That Influenced the Change Management Practices**

There were a number of factors that impacted negatively on the change outcome according to those interviewed at the hospital. The actual implementation approach substantially varied from the planned approach and change initiatives were sometimes centralized and this affected the processes of ownership and innovation.

#### 4.7.1 Culture and Organizational Change

Burnes (2000) says that no organization has a static culture. As the external and internal business environment of the organization change so will the culture. He observes that organizations may at times find their culture inappropriate or even detrimental to their business. Kotter (1994) defines culture as norms of behavior and shared values among a group of people. He says that because of its near invisibility culture is difficult to address directly. When new practices made in a transformation effort are incompatible with the existing culture then the change will most likely falter. The research sought to know the importance that was attached to culture in the change process.

Several cultural issues obstructed change practices according to those interviewed. Although KNH has a budget of its own, hospital operations are still somehow controlled by the ministry of health. This kind of bureaucracy resulted in delays in decision making and implementation of programmes and activities. A long hierarchy that requires all activities to be sanctioned at the highest level slows down decision making process wasting away opportunities for performance improvement. Those interviewed at various departments cited the culture of using committees as having pervaded Kenyatta National Hospital. The hospital has constituted a number of committees to assist in administration, managing of private practice and operation of clinical services. While Prasad (1989) points out the merits of using committees as being promotion of participation and the pooling of knowledge and experiences to arrive at better decisions, in KNH, the committee culture was thought to be the biggest contributor to slow decision or indecision. The culture was seen as promoting inaction by dissipating the point where the



final authority and responsibility rests. The change management purposely avoided to tackle issues before implementing the changes. This appeared to make sense because cultural issues in the public service are themselves complex, politically explosive and would require long periods of time to change. It was hoped that as the change progressed, those in the service would adapt to new values and expectations.

#### 4.7.2 Resistance

According to strebel (1996) change is disruptive and intrusive. It upsets the balance. Strebel further argues that managers should put themselves in their employees' shoes and look at the change from the perspective of the employees. Unless managers define the change terms and persuade employees to accept them, it is unrealistic to expect the employees to buy into the changes that seek to alter the status quo. Resistance to change is seldom openly voiced especially in situations that call for change in order to revitalize or turnaround an organization. However, resistance will manifest itself in delays and increased costs of implementing the change. The reasons for resistance are myriad and range from uninformed selfish motivated fears to genuine personal concerns such as in the case where job losses are likely. The research sought to know from the respondents if there was resistance and the probable reason for the resistance.

Those interviewed revealed that both behavioral and systemic resistance slowed the change initiative in addition to making the process more costly. Respondents indicated that individual resistance was posed mainly by members of staff. In November, 1991, the government tried the services of a team of expatriates, the International Hospital group,

to manage change in the hospital. A British expatriate, took over the running of the hospital as the chief executive following the signing of a 3-year contract between the government and the International Hospital group of the United Kingdom. The then hospital director, acted as a counterpart to the British expatriate. However, this arrangement did not last long. On hindsight, local clinicians resented the recruitment of the expatriate to manage change on high salaries without adequate consultations. The expatriate team was rejected.

In terms of systemic resistance, hospital capability too was cited as adversely influencing the change effort. The passive incompetence of the referral hospital on the information technology front was clearly found to be lagging behind hence did not provide reliable and timely information for decision making. In private wing for example data from various systems was done either manually or by using external storage devices. Good performance relies on relevant, accurate and timely information being available and the hospital therefore needs to consider how information systems can be put into place to support the change management process. With accelerating technological change, and the development of many beneficial and cost-effective technologies, there is a strong danger that the referral hospital will fall even further behind. Another problem was lack of adequate management skills and expertise to implement some of the change initiatives.

According to Burnes (2000) the best way to creating the willingness to change or overcoming resistance rests to involving and aligning people with the change. This requires that the people be made aware of the pressures of change, be provided with

regular feedback on the progress and honest and regular communication be sustained throughout the change and beyond. The purpose of the communication is to inform those who will be affected by the change, for this reason the communication should be honest. Communication does help overcome fears that may be associated with the change and also encourages facilitation of the change rather than result in sabotage.

#### **4.7.3 Teamwork**

Interview with some respondents revealed that the spirit of teamwork was lacking, yet through teamwork, pooling of talents and expertise would allow multifaceted problems to be dealt with. The respondents are aware of the immense benefits to be derived from working as a team. Such benefits were cited as fostering support for discussion, broadening the knowledge of team members, improved communication and better motivation. The main task of the team is to build the hospital's vision and strategy, translating it into plans and objectives for the hospital to implement. Team members will need skills in problem solving, planning and performance management. The hospital management team needs to have a consistency of membership which could, for instance, include the chief executive, Matron, Finance Director, Medical Director, a clinical support services Director, plus one or two key players e.g. a planner, an information specialist, a human resource director or a works director. The important thing is that the top team should include a selective spread of the key functions and the key leaders, influencers and opinion formers in the organization and should not exceed seven in number. The team members should be capable of team working, corporate vision, and loyalty and of personal competence both as individuals and as part of the team effort.

#### **4.7.4 Leadership**

Leadership for a successful change programme calls for commitment, resourcefulness and enthusiasm from those who provide it. Leadership is described as involving a combination of elements namely; establishing the overall direction through vision and awareness of the changes necessary to bring about the vision; creating and maintaining the confidence and energy to mobilize action and ensure that all various hurdles in the way of change are surmounted. Leadership for the change initiative was provided by the hospital director and heads of departments. Interviewees with heads of departments about the quality of leadership revealed that both present and past hospital directors were helpful in ensuring that the change initiative was on course.

The researcher attempted to map employees and the government as the main stakeholders in terms of the impact of the change and the support that these stakeholders are likely to give to the change effort. Respondents indicated that both stakeholders had power and influence on the change process. Both were kept informed on the ongoing and therefore developed intellectual readiness.

#### **4.8 Lessons Learnt From the Change Program**

The lessons learnt according to the Performance Audit report of March, 2000 were; Despite the stated objective to reduce the hospital's budgetary burden, a number of reforms actually increased the volume and stability of flows to the hospital. First, the 50 percent wage increases of hospital staff also represented a significant increase in transfers, which are often implicitly guaranteed by treasury. Finally the changes invested

heavily in improved infrastructure and equipment, which has contributed to additional recurrent costs. The major objective of the change that is to reduce the percentage budget allocation to the referral hospital was not achieved. Several factors explain this; improved quality at the hospital together with a declining quality of city clinics has led to even higher congestion at the hospital. Although autonomous, the hospital is politically unable to fully enforce its referral role and turn away primary care patients. The AIDS epidemic also has led to increased number of severely ill patients, who are difficult to treat and often unable to pay.

Developing an appropriate legal and institutional framework for an autonomized hospital is clearly important, but will take time, negotiation and political support to translate autonomy on paper to autonomy in practice. Autonomization gives a greater discretion to management, but it does not ensure that increased discretion translates into improved performance, quality or efficiency. The governance of the institution including the selection process and criteria for hospital board members and the quality of leadership and management are critical. Therefore, increased autonomy alone is unlikely to release resources to support the shifting of service delivery to more cost effective settings. This suggests that future efforts to increase autonomy must directly address cost containment issues including the plans underway in Kenya to extend autonomy to a number of provincial hospitals.

Measurement of the right set of indicators can be a significant source of positive change. The KNH reform indicators focused on cost recovery and hospital efficiency such as

average length of stay. Internal support has been weak and the information collected is not always consistently collected and analyzed to track trends and identify areas of further improvements. However, the changes will in the long-run improve the allocation and mobilization of resources in the referral hospital. This will set an example for the rest of curative system, which could lead to further efficiency improvements at other hospitals in the future.

*5.1 Summary*  
The objectives of the study were: To establish the strategic change management practices of Kenyatta National Hospital, to establish the factors that are influencing the change management practices. In order to arrive at the results, the study examined the key strategic change practices by use of in-depth interviews directed at senior personnel who were involved in the change in one way or another and the gathering of secondary data related to the change. From the research data and other reports it is clear that the need for fundamental change at the referral hospital existed. If anything the change was overdue. Public dissatisfaction with declining quality led to growing hospital recognition of the need for reform. The referral hospital received severe criticisms from every quarter of the Kenyan society, and especially from the ordinary citizens who depended on the hospital for their everyday medical needs. Further government health funding declined greatly and KNH received a disproportionate percentage of public resources. This presented a challenge to the hospital management in seeking for best ways possible of sustaining quality health services within the framework of decreasing revenue from the central government.

The findings of the study indicate that the referral hospital followed the aspects of strategic change management in its change program. Though not quite direct, the researcher could remotely pick Kotter's Ten Commandments of ensuring change successfully. Addressing the organization and need for change, creating a shared vision

## CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

### 5.1 Summary

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The findings of the study indicate that the referral hospital followed the models of strategic change management in its change program. Though not quite distinct the researcher could remotely pick Kanter's Ten Commandments of executing change successfully. Analyzing the organization and need for change, creating a shared vision

and a common direction, use of guiding teams, involving people and being honest, lining up political support and reinforcing and institutionalizing change are some of the levers proposed by Kanter's model for successful change management practices that were applied in the referral hospital's change programme.

Several factors influenced the change management practices at the referral hospital. The process experienced both behavioral and systemic resistance. The information system did not provide adequate and reliable information to support decision making. The management skills to implement some change practices were not adequate. These problems arose because of the need to urgently implement the changes. Cultural issues affected the change practices. The culture of using committees pervades the hospital and was thought to be the biggest contributor to slow decision or indecision. Hospital operations are still somehow controlled by the ministry of health. This kind of bureaucracy resulted in delays in decision making and implementation of change.

## **5.2 Conclusion**

Though there are considerable achievements, the strategic objectives of the change program are yet to be fully achieved. Improved quality at the hospital together with declining quality at the city clinics has led to even higher congestion at the hospital. Despite the stated objective to reduce hospital's budgetary burden, a number of reforms actually increased the volume and stability of flow to the hospital. Even with satisfactory training output the referral hospital is still struggling to retain the necessary quota of skilled health care professionals and this is actually because it is unable to compete with



neighbouring countries in terms of pay and conditions. This means that change at the referral hospital is not effectively reinforced. This has led to the painful watch of the erosion of the distinctive advantages at the referral hospital. From this it can be concluded that reinforcement was seriously needed to sustain the improvements that has been realized. This position is so because Kenyatta National Hospital currently finds itself in a position needing new strategic direction with individual discretion and freedom to perform ensuring that where responsibilities are delegated, there is accountability and fair but rigorous review of performance and results.

## 5.2 Recommendations

Due to dynamism and complexity of change, change should be treated as an on-going process and not a one-off event that ends after certain activities are achieved. Instead different departments at the referral hospital should be encouraged to carry out reforms as a continuous day-to-day management activity. Departments should be challenged to identify necessary reforms that can make the hospital responsive to environmental change. They should then be empowered to implement the changes on a day-to-day basis.

### 5.4 Limitations of the Study

In change situations involving such public sector as Kenyatta National Hospital, it is desirable to use a change management model that seeks to involve people by equipping them with tools and skills to carry on with more change after the consultant has left. The issue of change in the public sector should be looked at critically with a view of giving it ownership. This is because it is difficult to pinpoint who owns the change and who it will benefit in the short and long term.

Change consultants should demystify the change process and equip organizational members with basic skills to diagnose and maintain the change on course. Otherwise given that change is normally packed with uncertainties, mistrust may result and lead to successive failure. Referral hospitals have an important role in the health care system and need to embrace rapid change in order to play their correct role in the changing scene of healthcare. Health managers can play a useful role in guiding change by disseminating advice in this field.

In the present climate of rapid health care reform, it is important that whilst not discouraging innovation, careful and systematic evaluation of policy, financial and technological innovations should be undertaken before moving to a wider implementation stage of the change program. Hospitals and other units within the health system should implement a change process by involving all the health professionals, led by an accountable chief executive supported by a senior management team which has its mission improved health care for its patients.

#### **5.4 Limitations of the Study**

Every study does encounter some level of limitations and this is because of scarcity of resources. The major resources that are required for such studies are time, backup personnel and finances. Scarcity of any of these resources translates to narrowing down the scope of the study and in the process some vital areas may be under-covered. The study depended largely on in-depth interviews and discussions with respondents still working. Senior staffs initially involved in managing the change practices have either

retired from the hospital or have been sacked. Though those who replaced them provided some information, personal experiences which are not in files were difficult to come by. However secondary data from reports was helpful. The study also focused on management and employee perspective. It would have been of value to obtain views of other stakeholders such as patients and suppliers.

## 5.5 Suggested Areas of Further Research

Change is such that it can never be said to have been mastered. This is because the environment is dynamic and it continuously presents new challenges, opportunities and other peculiarities. This results in the emergence of areas of interest that may require further study so as to give more completeness and greater understanding of the entire study area. A study should be undertaken to look at the impact of the implementation of strategic change to qualitative factors such as employee morale and customer satisfaction in order to arrive at more vital conclusions for decision making in managing strategic change.

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2. What were the strategic objectives of the change?

3. Who in the Hospital initiated the change?

4. Were the following preparations made before implementing change?

- 1) Assessment of the environment
- 2) Assessment of the resources to initiate change projects
- 3) Forming of change committees
- 4) Communicating to all stakeholders

#### SECTION (B) CHANGE MANAGEMENT PROCESS

5. Does the hospital have a vision?

6. Please describe the process of vision development stating those who were involved.

7. Was strategy developed?

8. Please describe the process of strategy development stating those who were involved.

# APPENDIX I

## INTERVIEW GUIDE QUESTIONNAIRE

To be answered by the Hospital Director.

### SECTION (A) FORCES OF CHANGE AND STRATEGIC OBJECTIVES

- 1 What forces necessitated change at KNH?
  - a).....
  - b).....
  - c).....
- 2 What were/are the strategic objectives of the change .....
- 3 Who in the Hospital initiated the change?.....
- 4 Were the following preparations made before implementing change?
  - 1) Assessment of the environment
  - 2) Assessment of the resources to initiate change practices
  - 3) Forming of change committee
  - 4) Communicating to all stakeholders

### SECTION (B) CHANGE MANAGEMENT PROCESS

- 5 Does the hospital have a vision?.....
- 6 Please describe the process of vision development stating those who were involved...  
.....
- 7 Was strategy developed?.....
- 8 Please describe the process of strategy development stating those who were involved?  
.....



SECTION (C) CHALLENGES ON CHANGE PRACTICES

9 How was vision communicated to all those involved in the change practices?

20 Are these currently promoted and hired according to their disposition to support the

10 Who among the following were involved in the change management practices?

Middle level

- 1) Top Management
- 2) Management
- 3) Employees
- 4) Consultants.

11 To what extent were the change practices pre-planned?.....

.....

12 Who was the leader of the change process?.....

13 How was urgency built to get employees co-operate and participate in the change process?.....

14 Were there specific teams mandated the responsibilities to implement the change in your hospital?.....

15 Please describe the process of team formation and the characteristics taken into account in picking members?.....

16 What was the role and powers of the teams?.....

17 How were the employees empowered to cope with the change?.....

18 What steps have been taken to ensure that the change goal is achieved?.....

.....

## SECTION (C ) CHALLENGES ON CHANGE PRACTICES

- 19 What are/were the notable challenges that the entire change process went through?
- 20 Are those currently promoted and hired screened for their disposition to support the change practices?
- 21 How have the following factors influenced the change management practices?

- 1) Resistance
- 2) Culture
- 3) Stakeholders politics
- 4) Teamwork
- 5) Leadership

- 22 How does the top Management indicate its support to the change practices? .....

.....

.....

- 23 What level of resources were/are allocated to the change process?

.....

.....

- 24 What are the visible benefits from the change realized by the hospital?.....

.....

.....

- 25 What are the visible benefits from the change realized by employees?.....

.....

.....

.....

Management Board

The Government

The Director

Senior Management

## APPENDIX II

### QUESTIONNAIRE

Faculty of Commerce, University of Nairobi

NOTE: The information in this questionnaire will be used strictly for academic purposes only and will be treated with utmost confidentiality.

Date:..... Questionnaire No:.....

#### SECTION (A) PERSONAL DETAILS

1. Position in the hospital.....
2. Department.....
3. Years of experience in the hospital 0 – 5 [ ] 5 – 10 [ ] 10 [ ] Tick

#### SECTION (B) FORCES OF CHANGE AND STRATEGIC OBJECTIVES

1. What forces necessitated change in your respective Department?
  - a).....
  - b).....
  - c).....
  - d).....
  - e).....
2. What were/are the strategic objectives of the change management practices?  
.....  
.....

#### SECTION (C) APPROACH TO CHANGE MANAGEMENT

- 1 Who in the hospital initiated the change management practices?

Management Board	[ ]
The Government	[ ]
The Director	[ ]
Senior Management	[ ]

Others (specify)..... (Tick)

2. Have external consultants been involved in the change management practices?  
Yes [ ] No [ ]

Please explain their involvement if at all .....

.....

3. To what extent have individual departments been allowed to initiate and implement change management practices?.....

### SECTION D CHANGE CONTENT

1. How has the change management practices affected either systems, services or behaviour?.....

.....

- 2 Please list the specific elements of the change management practices affecting systems or behaviour.

a).....

b).....

c).....

d).....

e).....

### SECTION E: CHANGE MANAGEMENT PROCESS

1. How was urgency built to get employees to co-operate and participate in the change process.....

.....

2. Were employees told about the change. (Tick appropriate)

Yes [ ] No [ ]

3. If the answer to question 2 above is yes, how was this communicated? (Tick)

- |            |     |                           |     |
|------------|-----|---------------------------|-----|
| Bulletins  | [ ] | Supervisor (face to face) | [ ] |
| Memos      | [ ] | Employee meetings         | [ ] |
| Newspapers | [ ] | Other specify .....       |     |

11. How do you carry out your training? (Tick)

4. Were there specific teams mandated the responsibilities to implement the change management practices in your Department?.....

.....

5. Please describe the process of team formation and the characteristics taken into account in picking members.

.....  
.....

13. Did you have short-term targets to monitor the change practice?

6. What was the role and powers of the teams?

.....  
.....

14. Yes [ ] No [ ]

7. Was any formal process used in undertaking the change? (Tick)

- Yes [ ] No [ ]

SECTION 5: FACTORS THAT HAVE INFLUENCED THE CHANGE

8. How was the change carried out? (Tick)

- At once [ ] Continuous [ ] Gradually [ ]

15. How do you monitor the change process? (Tick)

9. How were employees empowered to cope with change? (Tick)

- |                                     |     |
|-------------------------------------|-----|
| Training                            | [ ] |
| Involvement in identifying solution | [ ] |
| Excluded                            | [ ] |

- 10 How often do you train your employees? (Tick)
- Every 3 months [ ]
- Every year [ ]
- Hardly ever [ ]

11. How do you carry out your training? (Tick)
- In-house [ ]
- External [ ]
- Combination of the two [ ]

12. What steps have been taken to ensure that the change goal is achieved ?

.....

.....

13. Did you have short-term targets to monitor the change practices?

Yes [ ] No [ ]

14. Were those who achieved such targets rewarded?

Yes [ ] No [ ]

**SECTION F: FACTORS THAT HAVE INFLUENCED THE CHANGE MANAGEMENT PRACTICES**

1. Please list in order of importance the factors that have influenced the change management practices. (Focus on resistance, culture, stakeholder politics, teamwork , Leadership)

- a).....
- b).....
- c).....
- d).....
- e).....

2. How was the resistance overcome?.....  
.....

3. Have the changes been of any benefit? (Tick)

Yes [ ]                      No [ ]

4. If the change was beneficial, please list the benefits.

a) To employees

1.....

2.....

3.....

b). To the organization (KNH)

1.....

2.....

3.....

b) To the public (stakeholders)

1.....

2.....

3.....

THANK YOU VERY MUCH FOR TAKING YOUR TIME TO COMPLETE THIS QUESTIONNAIRE.